MAIN OFFICE

One Charles Park
Cambridge, MA 02142-1206
Phone 617-679-MTRS (6877)
Fax 617-679-1661

WESTERN REGIONAL OFFICE

101 State Street, Suite 210
Springfield, MA 01103-2066
Phone 413-784-1711
Fax 413-784-1707

ONLINE

mass.gov/mtrs

MTRS
MASSACHUSETTS TEACHERS' RETIREMENT SYSTEM

Form LEG-F0010-DRA-10212008

Name _____
Last *First* *MI*

☐ Accidental ☐ Ordinary ☐ Both

Disability Retirement Application

INSTRUCTIONS

- In order to apply for disability benefits, you must complete the questions and forms contained in this application. This application consists of:
  - ☐ Information and answers you must provide . . . . . pages 1–14
  - ☐ Authorizations for release of information
    - Insurance records 15
    - Protected health information 16
    - Tax records 17
  - ☐ Medical Panel selection form 18
- Before you begin to fill out this application, please refer to our booklet, *What You Should Know About Disability Retirement,* for general information and eligibility requirements regarding disability retirements. If you have any questions or need clarification, please contact our Disability Case Manager for help.
- **Do not delete any pages from this application. If necessary, please attach additional sheets.**
- **As required, please print your responses legibly, in ink.**
- The ☑ symbol means that you must submit the document listed in the margin along with your application.
- Be sure to **complete the entire application,** including the release forms, and attach all required documents before returning your application to our office. **If your application is incomplete, we will return it to you and this will delay processing.** We cannot assign a date of application—which is very important in determining the effective date of your retirement if your application is approved—until you have submitted all required information.
- Before you send the application and your documents to us, make a photocopy of all pages for your records.
- After you have completed this application, gathered the required documents and made a photocopy for your records, please send your materials to:

  Disability Case Manager
  Massachusetts Teachers' Retirement System
  One Charles Park
  Cambridge, MA 02142-1206

Member name _____

☐ Accidental ☐ Ordinary ☐ Both

SSN _____

Applicant data

- Type of disability retirement applied for ..... ☐ Accidental ☐ Ordinary ☐ Both
- Social Security number, XXX-XX-XXXX ..... _____
- Gender ..... ☐ Male ☐ Female
- Name _____
  Prefix, if any First Middle Last Suffix, if any

Marriage certificate *(photocopy OK)*

Former/maiden name, if applicable ..... _____

Certified birth record

- Date of birth , mm/dd/yyyy ..... _____
- Mailing address _____
  Number and street Apt.

  _____
  City State ZIP

  Home phone (_____) _____ E-mail _____
- Marital status ..... ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Military discharge form DD214

- Veteran status ..... ☐ Nonveteran ☐ Veteran
  Dates of active military service: mm/yyyy
  From _____ to _____
  Total year(s) _____
- MTRS RetirementPlus status ..... ☐ Nonparticipating ☐ Don't know
  ☐ Participating (elected in)
  ☐ Participating (mandated)
- **Alternate address**: If you will be residing at an address other than the one above (for example, a summer or retirement address) within the next 12 months, please list below.

  Alternate address _____
  Number and street Apt.

  _____
  City State ZIP

  Phone (_____) _____ Dates here: From _____ to _____
  mm/yyyy mm/yyyy

Attorney data

If applicable

If you are represented by an attorney in this disability retirement application process, please provide the following information so that we may contact him or her as necessary.

- Name _____
  Prefix, if any First MI Last Suffix, if any
- Firm _____
- Address _____
  Number and street Suite/Floor

  _____
  City State ZIP
- Phone (_____) _____ Fax (_____) _____

Member name _____

☐ Accidental ☐ Ordinary ☐ Both

SSN _____

Applicant's statement

■ I, _____, hereby make application for disability retirement benefits pursuant to Massachusetts General Laws, c. 32, sections 6 or 7.

The incapacity described is not the result of serious or willful misconduct on my part.

If I am applying for accidental disability benefits, I state that the incapacity described herein and in the written materials accompanying this application, was sustained as a result of an injury or hazard that I underwent as a result of my employment and while in the performance of my duties.

I do hereby certify that this statement, together with the statements made herein and on the written materials accompanying this application, are made under the pains and penalties of perjury and are true and accurate to the best of my knowledge and belief. I acknowledge that this application is made subject to the criminal forfeiture provisions of G.L. c. 32, section 15 and the other requirements and provisions of applicable law, including Chapter 32 of the Massachusetts General Laws and titles 807 and 840 of the Code of Massachusetts Regulations.

Applicant's Signature _____ Date _____

Employment history

■ **Current position** (position you are retiring from)

Title _____

School district _____ Grade(s) taught _____

Dates employed From _____ (mm/yyyy) to _____ (mm/yyyy) Date when you last worked _____

School _____

Phone (_____) _____ Fax (_____) _____

Name of superintendent _____ Phone (_____) _____

Name of principal _____ Phone (_____) _____

Name of immediate supervisor _____ Phone (_____) _____

■ **Creditable service estimate**

Please indicate your approximate number of years of creditable service..... _____

Member name _____

☐ Accidental ☐ Ordinary ☐ Both

SSN _____

■ All Previous Employment

Please list all previous employment in chronological order, beginning with your oldest position and ending with your current position. If you have ever been employed by any other Massachusetts state governmental agency or unit, you may be eligible to purchase creditable service for that employment. If you list the Commonwealth of Massachusetts as a previous employer, please check the box in the last column (MA public service).

Period of employment **From** (mm/dd/yyyy)	**To** (mm/dd/yyyy)	**Employer's name/ address**	**If MA public service, please ✓ box**
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐

Primary treating physician

We will be requesting a statement certifying your disability status from the physician who is treating you for your disability. Please list the physician who has provided you with primary care in connection with your disability and from whom we should request this statement. **We recommend that you contact this physician to notify him or her that the MTRS will be sending him or her a Physician's Statement form to complete.** We will send you a copy of the completed Physician's Statement form.
[Note: If you are applying for disability retirement based on more than one condition, you must list one primary physician for each condition. If this applies to you, please check the box, below, and attach a separate sheet.]

■ Primary treating physician's name _____
Last First Middle

Address _____
Number and street City State ZIP

Phone (_____) _____

Additional condition(s) and primary physician(s): Please see attached sheet for additional physician listing(s).

Member name

☐ Accidental ☐ Ordinary ☐ Both

SSN

Disability and duties

- Please state the medical reason which is the cause of your application for disability.

- Please describe the essential duties which you are required to perform in your current position.

- How frequently are you required to perform the essential duties you described above?

- Please describe the essential duties which you are unable to perform as a result of your disability.

Recent physical activities

- For the period of the last year, please describe your physical activities, including:

  Medical rehabilitation activities

  Other employment activities since the onset of your disability

  Sports activities

  Activities of daily living (for example, driving, cleaning, etc.)

Member name _____

☐ Accidental ☐ Ordinary ☐ Both

SSN _____

Workers' compensation

We advise that you read this section carefully. It concerns the right of the MTRS to offset your disability retirement pension benefit by the amount of certain outside payments you may receive for the same injury.

Pursuant to Massachusetts General Laws, chapter 32, s. 14(2), the MTRS has the authority to offset from your disability pension the following payments you may receive as a result of the same injury for which you receive a disability pension:

- Any and all Workers' Compensation disability payments which you receive under Massachusetts General Laws, chapter 152, ss. 31 (survivor's benefits), 34 (temporary total), 34A (permanent and total), 34B (COLA), 35 (temporary partial) and 35A (dependent's benefits).
- Any recovery for lost wages you may receive from a third party other than your employer.

The statute also requires that you cooperate with the MTRS both in filing for and receiving Workers' Compensation benefits and pursuing and reporting any third party payments. If you do not cooperate in this regard, the MTRS has the authority to suspend your disability pension and/or file for Workers' Compensation or other benefits on your behalf. **Please note: You are required to notify the MTRS as to any change in rate of your Workers' Compensation benefit (including, but not limited to changes in COLA) or prior to any settlement of your Workers' Compensation or third-party (i.e., personal injury) claim. Failure to do so may result in an overpayment for which you will be liable.**

- Have you **applied for** Workers' Compensation benefits? ..... ☐ Yes ☐ No
  - If "yes," date you applied for Workers' Compensation, mm/dd/yyyy ... _____
  - **If "no:"**
    - **Please be aware that you must apply for Workers' Compensation benefits.**
    - Are you applying for an accidental disability retirement? ..... ☐ No ☐ Yes
- Have you **received** or are you **receiving** Workers' Compensation benefits or a settlement? ..... ☐ No ☐ Yes
  - If "yes," please provide the following information:
    - Type of Workers' Compensation receiving or received ..... ☐ Weekly benefits ☐ Settlement ☑
    - Date of initial payment, mm/dd/yyyy ..... _____
    - Amount of payment as part of a weekly/ biweekly benefits or settlement..... _____
    - Type of incapacity ..... ☐ Total ☐ Partial
    - Receiving workers' compensation COLA? If so, please provide the date you first received a COLA. _____
    - Name of attorney for Workers' Compensation Insurer ..... _____
    - Name and phone number of the Workers' Compensation insurance adjuster/claims representative for the school district/town or, if self-insured, name and phone number of the Workers' Compensation agent for the school district/town..... _____

      (_____)_____

☑ Copy of your settlement agreement

Member name _____

☐ Accidental ☐ Ordinary ☐ Both

SSN _____

Salary data

In order for us to calculate your potential disability retirement benefits, we need information regarding your regular compensation. Please report **either** your three highest consecutive years' regular compensation **or** your last three years' regular compensation, whichever is greater. Please note:

- Please report your contracted salaries for four school years.
- You must submit copies of your contracts verifying your regular compensation listed here. Be sure to include payment schedules or contractual language to substantiate any earnings in excess of your regular contract rates.

	School Year From (mm/dd/yyyy)	School Year To (mm/dd/yyyy)	Regular Compensation $	
☑ Contract	_____	_____	_____	☑
☑ Contract	_____	_____	_____	☑
☑ Contract	_____	_____	_____	☑
☑ Contract	_____	_____	_____	☑

- As of the date of this application, what is your salary status? ..... ☐ Paid leave ☐ Unpaid leave ☐ Sick bank ☐ Workers' Compensation

- If you are a veteran, please also list your regular compensation for the last 12 months.

	School Year From (mm/dd/yyyy)	School Year To (mm/dd/yyyy)	Regular Compensation $	
☑ Contract	_____	_____	_____	☑
☑ Contract	_____	_____	_____	☑

Option C beneficiary data

If your application for disability retirement benefits is approved, you may choose to receive your payment under Option A, B or C. If you are considering Option C—which allows for a monthly survivor benefit—you must provide the following information regarding your beneficiary. By completing this section, you are not choosing Option C, you are simply providing us with the information necessary to calculate the Option C benefit. Note:

- Under Option C, your beneficiary must be your parent, sibling, child, spouse or former spouse who has not remarried.
- You must also submit your beneficiary's certified birth record.
- If your beneficiary is your spouse or a former spouse who has not remarried, you must also submit a copy of your marriage certificate.

- Name _____
  Prefix First MI Last Suffix

☑ Certified birth record

- Date of birth ☑ _____ Social Security number _____

☑ If spouse or former spouse, marriage certificate *(photocopy OK)*

- Relationship to applicant ..... ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Child ☐ Spouse ☑ ☐ Former spouse who has not remarried ☑

Member name

☐ Accidental ☐ Ordinary ☐ Both

SSN

Dependent child data

Please record the names, birth dates and Social Security numbers of your children who are:

- under age 18;
- over age 18 and under 22 who are full-time students; and
- over age 18 and physically or mentally incapacitated from earning.

Name (first MI last)	**Gender**	**Date of birth** (mm/dd/yyyy)	**Social Security number**	**Status** *(check one)* Under 18	Student 18–22	Incapacitated over 18
	☐ M ☐ F					
	☐ M ☐ F					
	☐ M ☐ F					
	☐ M ☐ F					

Note to applicant

- If you are applying for retirement based on:

  Ordinary disability only, skip to page 13 (Medical history).

  Accidental disability only, or both accidental and ordinary disability, please continue on page 8.

Member name

☐ Accidental ☐ Ordinary ☐ Both

SSN

Reason for accidental disability

One of the conditions for receiving approval of your application for accidental disability retirement benefits is that the Board must find that the disability is the natural and proximate result of either

- **the personal injury you sustained** (usually, one or several specific incidents) or
- **the hazard undergone** (generally, exposure to a harmful situation over a period of time).

■ Please identify the reason for your disability ..... ☐ Personal injury sustained ☐ Hazard or exposure undergone

■ Being as specific as possible, please describe either the personal injury you sustained or the hazard/exposure undergone

- Date(s) _____
- Specific time(s) or if hazard/exposure, length of time exposed _____
- Location(s) _____
- Description of incident(s) or hazard/exposure _____

■ Please describe the job duties you were performing immediately prior to and during the time of the personal injury you sustained or the hazard/exposure undergone

Member name _____

☐ Accidental ☐ Ordinary ☐ Both

SSN _____

Witness data

- Did anyone witness the incident(s) or hazard/exposure described above? ..... ☐ No ☐ Yes
  - If "yes," please provide the following information for each witness:

- Name _____ (Last / First / MI)
  Address _____ (Number and street / Apt. / PO Box)
  _____ (City / State / ZIP)
  Phone (_____) _____ Relationship to applicant _____

- Name _____ (Last / First / MI)
  Address _____ (Number and street / Apt. / PO Box)
  _____ (City / State / ZIP)
  Phone (_____) _____ Relationship to applicant _____

- Name _____ (Last / First / MI)
  Address _____ (Number and street / Apt. / PO Box)
  _____ (City / State / ZIP)
  Phone (_____) _____ Relationship to applicant _____

Incident reports

- Have you filed a report of the incident(s) or hazard/exposure described above with any person or agency? ..... ☐ No ☐ Yes
  - If "yes," please provide the following information for each person or agency.

- Name _____ (Last / First / MI)
  Agency _____
  Address _____ (Number and street)
  _____ (City / State / ZIP)
  Phone (_____) _____ Date report filed _____

☑ Claim or incident report

- Name _____ (Last / First / MI)
  Agency _____
  Address _____ (Number and street)
  _____ (City / State / ZIP)
  Phone (_____) _____ Date report filed _____

☑ Claim or incident report

Member name _____

☐ Accidental ☐ Ordinary ☐ Both

SSN _____

Insurance coverage

- Do you have any insurance coverage which relates to the incident(s) or hazard/exposure described above? ☐ No ☐ Yes
  - If "yes," please provide the following information for each policy. Additionally, please note: The MTRS requires that you sign an *Authorization for the release of insurance records*. This form is on page 15 and allows the MTRS to request copies of your insurance records from the insurers you list below for the period of the last five years.

- Agent's name _____ (Last / First / MI)
  Agency _____
  Address _____ (Number and street)
  _____ (City / State / ZIP)
  Phone (_____) _____ Type of coverage _____

- Agent's name _____ (Last / First / MI)
  Agency _____
  Address _____ (Number and street)
  _____ (City / State / ZIP)
  Phone (_____) _____ Type of coverage _____

Emergency medical treatment

- Did you receive emergency medical treatment as a result of the incident(s) or hazard/exposure described above? ☐ No ☐ Yes
  - If "yes," please provide the following information for each physician from whom you received treatment. Additionally, please note: The MTRS requires that you sign an authorization for the release of protected health records. This form is on page16 and allows the MTRS to request copies of your medical records from the facilities and physicians you list below.

- Treating physician's name _____ (Last / First / MI)
  Hospital/facility _____
  Address _____ (Number and street)
  _____ (City / State / ZIP)
  Phone (_____) _____ Date(s) of treatment _____

- Treating physician's name _____ (Last / First / MI)
  Hospital/facility _____
  Address _____ (Number and street)
  _____ (City / State / ZIP)
  Phone (_____) _____ Date(s) of treatment _____

Member name _____

☐ Accidental ☐ Ordinary ☐ Both

SSN _____

Medical treatment

- Have you received any medical treatment as a result of the incident(s) or hazard/exposure described above? ☐ No ☐ Yes
  - If "yes," please provide the following information. Additionally, please note: The MTRS requires that you sign an authorization for the release of protected health records. This form is on page 16 and allows the MTRS to request copies of your medical records from the facilities and physicians you list below.

- Primary care physician's name _____
  Last First MI

  Address _____
  Number and street City State ZIP

  Phone (_____) _____

  Date(s) of treatment _____

  Nature of treatment _____

  _____

  _____

  _____

- Primary care physician's name _____
  Last First MI

  Address _____
  Number and street City State ZIP

  Phone (_____) _____

  Date(s) of treatment _____

  Nature of treatment _____

  _____

  _____

- Did you take any time off from your employment? ☐ No ☐ Yes
  - If "yes," please list date(s) and time(s) _____

    _____

- Did your physician(s) recommend any rehabilitation? ☐ No ☐ Yes
  - If "yes," please describe any rehabilitation you have undergone _____

    _____

Member name _____

☐ Accidental ☐ Ordinary ☐ Both

SSN _____

Other actions taken

- As a result of the incident(s) or hazard/exposure described above, did you file a grievance pursuant to your collective bargaining agreement? ..... ☐ Not applicable ☐ No ☐ Yes
  - If "yes," please describe the status of your grievance _____

- As a result of the incident(s) or hazard/exposure described above, was any administrative or disciplinary action taken by your employer? ..... ☐ No ☐ Yes
  - If "yes," please explain _____

- As a result of the incident(s) or hazard/exposure described above, did your employer conduct any tests or studies on any area of the school building or grounds or make any repairs in such areas? ..... ☐ Not applicable ☐ No ☐ Yes
  - If "yes," please explain _____

Other conditions

- **Contributing conditions or events**

  Please describe any other circumstances, events or physical conditions that contributed or may have contributed to your disability.

Member name

☐ Accidental ☐ Ordinary ☐ Both

SSN

Medical history

The following sections relate to **any** medical treatment you have received.

■ Prior illnesses, accidents or injuries

Please list **all** prior illnesses, accidents or injuries you have had, beginning with the oldest occurrence and ending with the most recent one.

Date(s) From (mo/day/yr)	To (mo/day/yr)	Description of illness, accident or injury	Medical treatment received

■ Hospitals, medical facilities or institutions

Please list all hospitals, medical facilities or institutions which you have consulted or at which you received any treatment, beginning with the oldest occurrence and ending with the most recent one. Additionally, please note: The MTRS requires that you sign an authorization for the release of protected health records. This form is on page 16 and allows the MTRS to request copies of your medical records from the facilities you list below.

Date(s) From (mo/day/yr)	To (mo/day/yr)	Name of facility/ address/ phone number	Reason for visit

Member name _____

☐ Accidental ☐ Ordinary ☐ Both

SSN _____

Medical history

Continued

■ Physicians

Please list all physicians whom you have consulted or from whom you received any treatment, beginning with the oldest consultation and ending with the most recent one. Additionally, please note: The MTRS requires that you sign an authorization for the release of protected health records. This form is on page 16 and allows the MTRS to request copies of your medical records from the physicians you list below.

Date(s) From (mo/day/yr)	To (mo/day/yr)	Name of physician/ Address/ Phone number	Reason for consultation

Paid and unpaid leaves

As a result of time away from your employment, if any, because of your disability, have you

- taken any paid sick leave? . . . . . ☐ No ☐ Yes; from _____ to _____
- taken any paid vacation time? . . . . . ☐ No ☐ Yes; from _____ to _____
- taken any unpaid sick leave? . . . . . ☐ No ☐ Yes; from _____ to _____
- taken any unpaid leave? . . . . . ☐ No ☐ Yes; from _____ to _____

Note to applicant

Please continue on page 15. The release forms on the remaining pages must be completed by all applicants.

MTRS
MASSACHUSETTS TEACHERS' RETIREMENT SYSTEM

Main Office
One Charles Park
Cambridge, MA 02142-1206
Phone 617-679-MTRS (6877)
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Online mass.gov/mtrs

Applicant's authorization for release
MTRS request

Insurance Records

Applicant's statement and authorization for release of insurance records

To be completed by applicant

■ Re: _____
Name of applicant/record subject

_____
Number/street

_____
City State ZIP

_____ _____
Social Security number Date of birth

■ I authorize the MTRS to submit this release to, and to request my insurance records from, any insurer or agency I have listed in this Disability Retirement Application.

Additionally, I understand that if the insurer or agency charges any fee for providing these records, I will be responsible for the payment of such fee. If I do not agree to pay, I understand that my application may not be processed.

I authorize the below-named individual, insurer or agency to release to the Massachusetts Teachers' Retirement System any and all information, reports and records it may have regarding any application or claim for insurance I have made during the five (5) years preceding the date beside my signature, below. The scope of this authorization includes the release and copying of such information, reports and records, including but not limited to: correspondence, application forms, claim forms and medical examinations. A photocopy of this document, including my signature, shall be as valid and effective as the original.

■ Signature _____ Date _____

Request for insurance records

To be completed by MTRS

■ **Keeper of the Records**

_____
Name of insurer and/or agency

_____
Number/street

_____
City State ZIP

_____ _____
Name of record subject's employer/group Policy/certificate number

■ Date of request _____

■ Please forward records by _____

■ **To the Keeper of the Records:** You have been named as having provided insurance coverage by the above-noted individual in his or her application for disability retirement. In accordance with the above authorization, please submit your insurance records regarding this individual, by the forwarding date indicated, directly to:

Disability Case Manager
Massachusetts Teachers' Retirement System
One Charles Park
Cambridge, MA 02142-11206

Please include a copy of this sheet with any records that you send us. If you have any questions, please contact the Disability Case Manager immediately at 617-679-6877. Thank you for your cooperation and assistance.

MTRS
MASSACHUSETTS TEACHERS' RETIREMENT SYSTEM

Main Office
One Charles Park
Cambridge, MA 02142-1206
Phone 617-679-MTRS (6877)
Fax 617-679-1661
Online mass.gov/mtrs

Retirement Board Authorization to

Use or Disclose Protected Health Information

Please note:

- All numbered entries must be completed for this authorization to be valid.
- Please note, Retirement Boards are not covered entities under the Health Insurance Portability and Accountability Act (HIPAA), however all information is treated in a confidential manner consistent with Federal and State privacy laws.

1. I hereby authorize: _____
(physician, hospital, insurance company, employer, other health/rehabilitation entity)

to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to Federal or State law protecting its confidentiality. Information released on this authorization, if redisclosed by the recipient, is no longer protected.

2. Patient Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

3. Information to be disclosed to: Massachusetts Teachers' Retirement System
One Charles Park
Cambridge, MA 02142-1206

4. Please check the box below to authorize release of your complete medical record, or, use the lines below to stipulate any exceptions.

Authorize Release of Complete Medical Record

Exceptions: _____

_____

5. I have checked the box below indicating the purpose for the disclosure of this information.

Disability Retirement Application: (G.L. c.32, §6 & §7)

Restoration to Service Evaluation (including rehabilitation): (G.L. c.32, §8)

Accidental Death Benefit: (G.L. c.32, §9 & §100)

6. I understand I may revoke this authorization at any time by notifying the Retirement Board in writing, unless action has already been taken in reliance upon it, or during an appeal under the applicable law.

7. This authorization will expire upon final determination of my disability application or Comprehensive Medical Evaluation/Rehabilitation/Restoration to Service process or up to one year from date signed below.

8. _____
Signature of Patient or Legal Representative

10. _____
Date

9. _____
Printed Name of Patient or Patient's Representative

_____
Relationship to Patient/Authority to Act for Patient if Applicable

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Applicant's authorization for release of

Tax Records

Applicant's statement and authorization for release of tax records

To be completed by applicant

■ Re: _____
Name of applicant/record subject

_____
Number/street

_____
City State ZIP

_____ _____
Social Security number Date of birth

■ I understand that I am obliged to authorize the release of my tax records from the Federal Internal Revenue Service and/or the Massachusetts Department of Revenue. Additionally, I understand that if my application for disability retirement is approved by the MTRS, I will be required to authorize annual releases of my tax records to the MTRS by signing any release form(s) as required (IRS form 4506 and Public Employee Retirement Administration form WM 394). I also understand that my failure to provide such future authorizations may result in the suspension and/or termination of my disability benefits.

■ Signature _____ Date _____

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One Charles Park
Cambridge, MA 02142-1206
Phone 617-679-MTRS (6877)
Fax 617-679-1661
Online mass.gov/mtrs

Disability applicant's Medical Panel selection form

Instructions to applicant

All applicants for disability retirement must complete this form. And, unless the MTRS denies your application as a result of an initial fact-finding hearing, you must have a medical panel examination. The Public Employee Retirement Administration Commission (PERAC) appoints all medical panels. No member can receive a disability retirement unless the medical panel certifies to the MTRS that the member is disabled, that the member's disability is likely to be permanent and, in the case of an accidental disability application, that the member's disability is causally related to employment. (If the acceleration of a pre-existing condition is as a result of an accident or hazard undergone in the performance of the member's duties, causation would be established.)

If and when your case is at this stage, we will request that PERAC convene a medical panel, taking into consideration the nature of disability claimed, the type of doctors you have recently seen and where you live. PERAC pays the fees of the physicians on the medical panel. The medical panel will consist of three doctors; by law, the physicians cannot be members in an associated practice. Prior to the examination, we will forward copies of your medical records to each of the physicians for their review.

You have the choice of having the three physicians appointed to the medical panel examine you

- as a group, regional medical panel (in one examination at one place at one appointment time) **OR**
- individually (in three separate examinations, potentially at three different locations at three different times).

By way of this form, you are selecting the type of medical panel examination you want. The statute requires that medical panel examinations take place as soon as possible at a time and place that is convenient for all parties. If you select a group panel and the panel fails to meet within 60 days of its appointment by PERAC, then PERAC will automatically schedule three separate examinations. You can amend your selection at any time during the 60 days after the panel has been appointed.

Please complete the Applicant Data and Medical Panel Selection sections, below.

Applicant data

- Type of disability retirement applied for . . . Accidental Ordinary Both Accidental and Ordinary
- Name _____
  Last First Middle

  Current Address _____
  Number and street Apt. PO Box

  _____
  City State ZIP

  Phone (_____) _____ SSN _____

Medical Panel selection

- I, the undersigned, having applied for disability retirement from the Massachusetts Teachers' Retirement System, understand that in order to receive approval of my application, I must be examined by a three-physician medical panel appointed by the Commissioner of the Public Employee Retirement Administration Commission. I hereby select the following type of medical panel (check one):

  A regional medical panel (group exam) **Separate appointments** (individual exams)

- I understand that:
  - If I do not select a type of medical panel, a group panel will automatically be assigned to examine me.
  - If I fail to appear at any of the scheduled medical appointments, my application may be denied by the MTRS.
  - If I am unable to attend a scheduled medical appointment, I must give the Commissioner of PERAC reasonable notice, and if I do not provide reasonable notice to PERAC, I may be responsible for payment for the appointment. I may request that the appointment be rescheduled, but I understand that the Commissioner ordinarily only reschedules appointments as a result of extenuating circumstances such as death in the member's family or hospitalization of the member. If the Commissioner denies my request for rescheduling and I fail to appear at the originally scheduled appointment, the MTRS may deny my application and notify me and all parties of its decision and appeal rights.
  - If I select a regional medical panel and the panel fails to meet within 60 days of its appointment, PERAC will schedule separate appointments with three physicians.
  - I may change the type of medical panel I have selected within 60 days of its appointment by PERAC; to do this, I must submit an amended Medical Panel Selection Form (available upon request) to the MTRS.

Applicant's signature _____ Date _____